



Consensus on the NCL Primary & Secondary Care Interface

Interface Steering Group



North Central London
Integrated Care System

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This document was updated in collaboration with the following groups and organisations:

- NCL Referral Interface Group
- University College London Hospital Clinical Interface Group
- Royal Free London Clinical Interface Group
- Whittington University Hospital Clinical Interface Group
- North Middlesex University Joint Planned Care Board & Clinical Interface Group

Owned and maintained by North Central London Integrated Care Board – update endorsed by the NCL Referral Interface Group (RIG).

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Foreword

The focus for the North Central London Integrated Care System is on providing care and support that improves the health and wellbeing of everyone living in our boroughs. North Central London Integrated Care system and Integrated Care Board were formally established in July 2022. Despite the challenges of the past few years, we continue to build stronger partnerships, relationships, and develop new ways of working as a system. There is more we can do to establish joint working arrangements and empower clinicians to collaborate better across primary and secondary care. Moreover, we believe that these joint arrangements will reduce administrative workload across the system, freeing up professionals' time and improving patient experience.

Trust and effective communication between professional colleagues across organisational boundaries is a key requisite in creating this system, in order to build confidence in our expected behaviours and actions. This personification of trust and mutual accountability is contained within this document, and it should be seen as a starting point for local conversations. Through creating local connections and relationships, we hope to recognise and eliminate the gaps between our services. Our patients rightly expect us to work collaboratively as one team, and this will only be achieved through developing ever closer working relationships over time. At times these changes will feel tricky and challenging. With ever increasing competing priorities it is key we treat each other with kindness and compassion and find ways to improve the patient and workforce experience.

This document is split into three sections, with recommendations for both primary and secondary care clinicians. Where medicines prescribing, supply, monitoring or shared care arrangements are involved, the NCL Interface Prescribing Guidance (IPG) should be followed. We have been excited to hear enthusiasm from other sectors, such as tertiary care, community, and mental health for a similar consensus that enables closer working across all organisations within our wider system and hope to use the lessons learnt from this Primary and Secondary Care Consensus to replicate the process elsewhere.

This document is not exhaustive, and there will occasionally be clinical scenarios which do not fit neatly into one of examples below. To that end, we continue to rely on clinicians' professional judgement in managing these cases. Moreover, these principles should not be viewed as 'rules' to be strictly followed, but instead as best practice recommendations that help us to keep the patient at the centre of all we do, especially during the transitions back and forth between organisations.

We hope that this Consensus document, and its Summary version, prove useful to front-line staff in delivering collaborative and seamless care between Primary and Secondary services. We also hope that it serves as a useful stimulus for local teams to consider their response and how they may work more closely together moving forwards.

I am immensely grateful to all the colleagues involved in the development of this shared Consensus document and to Dr Jay Mehta and Sophie Donellan for their support. Thank you particularly to all the chairs of Clinical Interface groups, LMC, GPPA, Medicines team and Dr John McGrath for their endorsement, contributions and leadership.

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Why are we doing this?

What is the Consensus?

The Consensus is a set of principles to guide NHS staff in North Central London working in primary and secondary care.

These principles should form our baseline expectations of each other and are not expected to supersede any existing local agreements.

Who are we?

The North Central London Integrated Care Board (NCL ICB) is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.

The Interface Steering Group (ISG) is a group of senior clinicians brought together by the ICB that represent primary and secondary care organisations across North Central London.

Why are we doing this?

We believe that, as a system, we can deliver the best care for our population and patients when we are able to collaborate and work together across organisational boundaries and disciplines.

This consensus is a key starting point for building these local relationships: by setting out the principles and behaviours that we believe are essential to deliver safe and sustainable patient care, we hope to build trust, mutual accountability and confidence in our expected behaviours and actions.

How can I help?

We want as many primary and secondary care staff in North Central London to engage with this Consensus and together drive better collaboration across the primary and secondary care interface.

We expect that this will not be a one-off or static process; as clinical medicine changes over time and our expectations of each other change, we must continually reinforce and update this consensus to meet current needs.

We therefore recommend all staff embed the principles of this consensus into their regular clinical ways of working and continually give us feedback on the areas that need updating.

What about other sectors?

This Consensus only covers the interface between the primary and secondary care sectors in NHS North Central London.

We will take the lessons learned from the development and implementation of this Consensus, and hope to replicate this process for tertiary care, mental health providers, community care providers, social care and further sectors over time. If you would like to volunteer to be part of this work, please contact us.

The following principles are supported by clinical and non-clinical staff across North Central London. They are not rules to follow and there will be exceptions. Clinicians are trusted to make appropriate decisions based on the individual circumstances they face. The underlying intent of this document is to improve relationships between colleagues, remove unnecessary administrative burdens and bring about a more efficient system for the benefit of all of the patients we serve.

This document should be used as a starting point for us to consider our own norms and ways of working, and initiate conversations across the system. It is expected to form our guiding principles, standardising the way we work across the NCL. This is work in progress and where local agreements are already in place, we expect those agreements to supersede this consensus and, over time as relationships strengthen and priorities align, we expect this to be adopted as the new standard.

What further progress has been made in 2025-26?

The Interface steering group was stood down at the end of 2024. Interface improvement programme 2024 objectives were agreed by primary and secondary care colleagues and work has progressed since then with oversight from the Referral Interface group which has clinical and operational representation from primary and secondary care. The new GP Feedback & Alert pathway being rolled out across NCL in March 2026 will support the implementation and embedding of this Consensus by highlighting any areas where its principles are not being followed, enabling a quality improvement approach

Further progress 2026 and beyond

With the merger of NCL and NWL ICB we will endeavour to bring further alignments across the West and North London ICB to address unwarranted variation and improve patient outcomes and workforce experience

Principles for all

1. **Treat all colleagues with respect.**
2. **Remember to keep the patient at the centre of all we do.**
3. **There is an underlying principle that clinicians should seek to undertake any required clinical actions themselves, without asking other teams to do this.**
 - a. Clinicians will, of course, need to operate within the limits of their professional competency and are only able to undertake actions if they have access to the relevant investigations or treatments.
4. **Whoever requests a test is responsible for the results of that test.**
 - a. This includes 'chasing' the results, receiving the results, acting on the results/determining the management plan, informing the patient of the results. and any other actions/onward referrals that may be needed
 - b. Consideration needs to be given to the management of incidental findings, whether these need further investigation and if so, by whom. We urge local organisations to clarify such pathways to avoid duplication, inappropriate investigation, or failure to further investigate where appropriate. In line with GMC guidance, we expect the requesting clinician to take responsibility for informing the patient of the findings and managing these, if within their competency. If urgent action is required, we would not expect this to be passed onto another clinician. Further clarification has been included in the amended onward referral policy (see below)
5. **Emergency Departments (EDs) and responsibility for tests.**
 - a. EDs should **not** ask GPs to chase acute investigation results or to onward-refer urgent suspected cancer or time-critical problems.
 - b. Non-acute abnormal findings in ED should generally be referred to primary care for further management. ED clinicians should advise patients to book a routine appointment with their GP for assessment and further investigation or treatment. They should also **avoid** asking the GP to contact the patient (unless vulnerable) for follow-up or for specific investigations or management. Where there are concerns regarding a vulnerable or frail patient, then proactive steps must be taken by the ED clinician to ensure that the patient has follow-up planned with primary care.
 - c. We recognise that transfers of care from ED attendances are a particular area of potential difficulty and would suggest that Royal College of Emergency Medicine (RCEM) [guidance](#) on this topic is implemented.
6. **Ensure robust systems are in place for patients to receive results of investigations, and that they understand what is going to happen.**
 - a. Secondary care should avoid directing patients to GPs for results and vice versa, unless agreed otherwise in a local pathway or shared care protocol.
 - b. Organisations should ensure processes are in place for patients to directly receive their results, instead of asking another clinician to follow them up.
 - c. Encourage the use of the NHS App (and equivalent secondary care trust apps where applicable)

7. **Ensure patients are kept fully informed regarding their care and ‘what is going to happen next’.**
 - a. This includes how they should raise concerns about clinical deterioration that avoids directing them to other services (unless appropriate such as a directive to attend ED when clinically required).
 - b. Ideally this should be in **written format** and referenced within the discharge summary, clinic outcome letters or consultation notes.
 - c. Patients should **not be used** as the main communication route for passing medical information between teams. Clinical communication is still required.

8. **Consider speaking to or messaging colleagues if in doubt.**
 - a. Organisations should consider how they might facilitate easy, prompt access to communicating with clinicians between different services.
 - b. This may include telephone calls, or asynchronous methods such as email (via a *secure nhs.net account*), Advice and Guidance, Consultant Connect and other models.
 - c. Practices and departments are encouraged to make their specific communication details clear on their correspondence, and to make their non-public/bypass telephone numbers available on the [NHS Service Finder](#).

9. **Consider a process of ‘Waiting Well’ for patients referred to secondary care.**
 - a. As a gold standard of practice, consider communicating with patients on waiting lists to ensure they know their referral has been received, how long they may wait and what to do in the event of deterioration in their condition.
 - b. This will likely require work at Place level across Primary and Secondary Care so that this process can start at the point of referral so that
 - i. The Primary Care clinician is empowered with knowledge of what to expect and red flags to watch out for, and
 - ii. Secondary Care teams who are aware of the length of their waiting lists are empowered to deliver regular and timely updates on the wait.
 - c. Consider Making Every Contact Count in all pathways, e.g., smoking cessation.

10. **When referring a patient to the Emergency Department, please ensure they are expected by, or have at least been signposted to a specialty team.**

11. **Both primary and secondary care clinicians should have regard to the [NCL EBICS \(evidence-based interventions and clinical standards\) policy](#) when considering an onward referral or treatment pathway.**

12. **The clinician wishing to initiate prescribed medication for a patient should undertake and document the appropriate pre-treatment assessment and counselling. Please refer to the [NCL Interface prescribing guidance](#) for further information**
 - a. They are responsible for communicating the rationale for treatment, including benefits, risks & alternatives, arranging any follow-up requirements that might be necessary, and documenting all of this in any related correspondence.
 - b. If the medication is subject to specific MHRA warnings (eg. for quinolones), discussion of this must be documented.
 - c. If prescriptions are to be continued by another clinician (e.g., a GP continuing a repeat prescription), the clinician initiating the medication should communicate the information above in a timely manner. See principles 24 25 and 27 below and

refer to the NCL Interface Prescribing Guidance.

- d. **Interface prescribing (shared care) and ongoing prescriptions**
 - i. Where a medicine is classified as Amber 2, Amber 3 or Amber 3ND, prescribing responsibilities must follow the arrangements set out in the NCL Interface Prescribing Guidance
 - ii. Primary care should not be asked to initiate medicines requiring shared care.
 - iii. Transfer of ongoing prescribing in primary care should only occur where the patient's condition is stable, the GP is sufficiently informed to be able to safely prescribe and monitor treatment and the shared care agreement is in place.

13. Try not to commit other individuals or teams to any action or time scale.

14. Use standardised referral forms and IT systems (e.g., Swiftqueue, T-Quest and eRS) where available.

15. It should be understood that patients do not always fit into pathways and secondary care should not automatically refuse a referral if it does not appear to fit the pathway.

Principles for Primary Care

16. When referring to secondary care please ensure you are clear in your 'ask'.

- a. Why are you referring this patient? Are you looking for advice, diagnosis or treatment? What are the patient's expectations?
- b. Please clearly articulate the reason for referral, and don't just put 'please see GP summary/consultation'.
- c. Ensure an up-to-date medication list is available along with investigations.
- d. Ensure patient contact details are up to date and highlight any vulnerabilities they may have in accessing care.
- e. Avoid unnecessary information in referrals but just include relevant test results and documentation. Refer to shared health records for further detail.
- f. If referring to request a diagnostic procedure, please check local pathways for direct access opportunities (e.g., endoscopy, MRI) first.
- g. Please avoid using abbreviations and acronyms. These may be common within your team but may not be understood in Secondary Care.
- h. Please use standardised referral forms where available. If not possible, ensure that all necessary information is provided in an appropriate format to avoid referrals being rejected.

17. When referring to secondary care please ensure appropriate Primary Care assessments have been made.

- a. Check local pathways for pre-referral criteria and required investigations (e.g., [NCL Website](#)).
- b. Refer to Single Points of Access (SPOAs) where available for enhanced triage.
- c. Consider advice and guidance, advice and refer and/or consultant connect.
- d. Consider other sources of help and guidance.
- e. Consider whether face-to-face assessment may add value before referral (both elective and emergency).
- f. Remember, it can be helpful to have a face-to-face conversation with a patient who requires an urgent referral (eg. urgent suspected cancer) to ensure they understand the pathway and to record their physical/frailty status.

18. When referring to secondary care please clearly communicate to the patient who they are being referred to, for what and what to expect (if known).

- a. Please advise the patient that waiting lists may be long and that their first contact may be a remote consultation.
- b. Consider the use of Easy Read patient leaflets (where available) to inform patients about their condition.
- c. Consider giving patients the contact details to be able to chase appointments themselves.

19. When referring with the expectation that an operative procedure may ultimately be required, please consider optimising any long-term conditions, and direct patients to [waiting well resources](#).

- a. BP control for hypertensives, glycaemic control for those with diabetes etc.
- b. Please empower patients to optimise their own health in the waiting period, e.g., smoking cessation referrals, weight management advice etc.
- c. This will reduce the impact of last-minute cancellations in pre-op clinic.

Principles for Secondary Care

20. Refer to the [NCL Onward Referral policy](#) for guidance on when to onward refer directly and when it is more appropriate to ask the GP to do so.

- a. **ANY suspected cancer or time critical problem** requiring further investigation or treatment, whether **RELATED OR UNRELATED** to the original condition **should be dealt with by making appropriate onward referrals and not** be sent back to the GP for onward referral. This includes Emergency Departments.
- b. For any suspected cancer or time critical problem identified in patients who are registered with a GP **outside** North Central London, the clinician should discuss with the patient whether they wish to be investigated within the trust or more locally. Should they choose the latter option, the clinician should explain that they will need to go back to their GP for referral to the most appropriate service.
- c. For any other newly identified clinical finding or non-urgent problem that is **unrelated** to the original reason for referral, and for which the clinician does NOT have adequate clinical information to take appropriate action, then the clinician should advise the patient to make an appointment with their GP for assessment and further investigation or treatment. If they have adequate clinical information, then the clinician should be able to take appropriate action and arrange onward referral. They should **avoid** asking the GP for specific investigations or management or to arrange follow-up.
- d. For a **non-urgent related** problem, the clinician should be able to take appropriate action and arrange onward referral.
- e. Clinical accountability lies with the clinician who has identified the need for further investigation or treatment and **will rely on the individual clinician's judgement** about what is best for the patient

21. Ensure clear and timely communication to GPs & patients after patient contacts.

- a. This applies to both Outpatients and on discharge from Inpatients and ED.
- b. Please highlight any changes in medication **with** reasons.
- c. Please avoid using abbreviations and acronyms. These may be common within your team but may not be understood in Primary Care.
- d. If follow-up in primary care is appropriate, be clear about what is required, how it will be provided and how any outstanding test results will be reviewed.
- e. Where feasible, local agreements on how best to keep GPs informed and sighted on patient progress is encouraged.
- f. Be explicitly clear about any requests/actions for the GP, for example if you are asking the GP to 'monitor' U&Es, please explain why, how often, for how long and what your expectations are if abnormal.
- g. If you need a repeat test within a short period of time, i.e. 2 weeks or less, please arrange this directly to avoid potential delays.

22. Do not ask General Practice to organise tests required for ongoing secondary care management.

- a. If a clinician wishes the patient to have their blood test closer to home, they should not ask GPs to request this.
- b. Trusts are encouraged to ensure that access to community phlebotomy and/or diagnostics are available, and that hospital teams are familiar with how these are accessed.
- c. If a clinician wishes the patient to have further tests prior to their next review or pre-operatively, they should request these investigations themselves.

- d. Surveillance should not generally require a new referral (e.g., 3-yearly endoscopy).

23. If a new, acute fit note (sick note) is indicated (e.g. following surgery), please provide it and do not ask patients to request it from their GP.

- a. Please also ensure this is given for the appropriate time period.
- b. Trusts should ensure fit notes are available in wards and clinics (electronic or hard copy), and that clinicians are familiar with issuing them.
- c. EDs are only expected to issue fit notes when it is anticipated that the patient will require more than one week off work. Patients can initially self-certify as sick for seven days.
- d. Where there is uncertainty about long-term fit notes, or reviewing fitness to return to work, please follow local trust guidance which has been developed in line with [national guidance](#)

24. If immediate treatment is required from Outpatients, please prescribe.

- a. We would suggest work on electronic prescribing for hospitals to community pharmacies (e.g. the [Electronic Prescription Service](#)) is accelerated.
- b. If EPS is not available, a hospital out-patient prescription or FP10 for community use should be provided to the patient and arrangements made for them to receive this if the appointment is virtual.

25. Discharge medications and outpatient prescriptions should cover the minimum duration (currently 14 days but for review in 26/27) specified in the [NCL Interface Prescribing Guidance](#)

26. Make use of the Discharge Medicines Service, nationally commissioned from community pharmacy

- a. This should be used for all appropriate patients to ensure they benefit from this essential service and that safety improvements are realised upon transfer of care.
- b. Ensure all electronic referrals made under this system contain the nationally agreed dataset.
- c. [The toolkit](#) references both high risk medicines and high-risk patients appropriate to send information on – this should be the minimum.

27. When recommending ongoing prescribing from the GP please ensure this is in line with [NCL Interface Prescribing Guidance](#) first

- a. Please check the suggested medication is appropriate for a GP to prescribe. See [NCL Red List](#)
- b. Document and communicate to General Practice your discussion with the patient on rationale for treatment, including benefits, interactions & contraindications, risks & alternatives, and any monitoring requirements, to avoid GPs repeating this consultation.
- c. **Interface prescribing (shared care)**
 - i. Where a medicine is classified as Amber 2, Amber 3 or Amber 3ND, prescribing responsibilities must follow the arrangements set out in the NCL Interface Prescribing Guidance
 - ii. Primary care should not be asked to initiate medicines requiring shared

care.

- iii. Transfer of ongoing prescribing in primary care should only occur where the patient's condition is stable, the GP is sufficiently informed to be able to safely prescribe and monitor treatment and the shared care agreement is in place.

28. Please consider arranging follow up plans for inpatients who self-discharge.

- a. By definition, these patients are likely to be unwell and vulnerable. They may have chosen to decline inpatient treatment, but they are still in need of our care, which may mean appropriate follow up in clinic is required.
- b. This also includes provision of appropriate discharge care and medication.

29. If a patient does not attend an appointment (especially vulnerable patients), the decision to discharge or reschedule should be made by a clinician who can review the reason for referral and judge the potential severity of disease.

- a. Consider whether the requirements of the [NCL Access Policy](#) have been met when arranging the appointment, including any adjustments needed for those patients requiring additional support.
- b. Ensure consideration has been taken regarding reasonable attempts for virtual appointments.
- c. Please ensure any discharge is addressed to the patient with both the reason and the trust's contact details, copied to the GP for information. Patients should be informed of the most appropriate contact details to rearrange within the leeway time offered rather than directed to their GP.
- d. If patients are transferred to patient-initiated follow up (PIFU) or seen on symptoms pathways, please ensure you clearly advise them of the criteria and instructions on how to access a further appointment.

Reference documents used to inform these principles

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Version History

Version	Summary of Changes	Date	Actioned By
0.1	First Draft	07/10/2022	Dr Jay Mehta, GP Registrar
0.2	Foreword and first review comments	20/10/2022	Dr John McGrath and Sophie Donnellan
0.3	Why Are We Doing This section added	09/11/2022	Dr Jay Mehta and Rachel Leuw
0.4	Feedback from consultation	08/06/2023	Dr Jay Mehta
0.5	Review on consultation update	22/06/2023	Dr Sonali Kinra and Sophie Donnellan
0.6	Formatting changes, incorporating feedback	29/06/2023	Dr Jay Mehta
0.7	Review and updated forward	13/07/2023	Dr Sonali Kinra and Sophie Donnellan
0.8	Feedback from LMC		Dr Sonali Kinra and Sophie Donnellan
0.9	Formatting changes and final checks	23/10/2023	Dr Sonali Kinra and Sophie Donnellan
1	Formatting changes and final checks	January 2024	Dr Sonali Kinra
1.1	Formatting changes. Links updated to NCL Interface Prescribing Guidance 2024/25 v13. Links updated from NCL MON website to NCL Health and Care website.	03/10/2024	Dr Sonali Kinra
1.2	Updated to include principles included in Onward Referrals policy	20/02/2026	Shirena Counter & Dr Sonali Kinra
1.3	Updated following discussion and feedback from the NCL RIG	05/03/2026	Shirena Counter & Dr Sonali Kinra
1.4	Final changes to wording following re-circulation to RIG and additional comments/additions	16/03/2026	Shirena Counter & Dr Sonali Kinra
2.0	Additions/changes to wording to align with the new NCL Interface Prescribing guidance. Checking of links	27/04/2026	Ey Cheung, Dr Sonali Kinra & Shirena Counter